

# PROACTIVE PATIENT REVIEW IN DIABETES: MARSH MEDICAL PRACTICE

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## BACKGROUND

People with type 2 diabetes (T2D) are 50% more likely to die prematurely than those without diabetes<sup>1</sup>. A common complication of diabetes that can lead to early death is cardiovascular disease (CVD). People with T2D are two to two-and-a-half times more likely to experience heart failure and twice as likely to have a heart attack compared to people without diabetes<sup>1</sup>. At least 10% of the entire NHS budget is spent on

diabetes each year, and almost 80% of this is spent on treating complications<sup>1</sup>.

Marsh Medical practice wished to adopt a proactive approach to optimising the management of patients with T2D, with a focus on CVD risk and status. The practice commissioned Interface Clinical Services, an IQVIA business, to perform the review and provide additional resource to help ensure continuity of care for patients during the COVID pandemic.

## AIMS

The aim of this service was to support Marsh Medical Practice to improve the quality of care, safety, and management of patients with T2D through proactive assessment of patients with a diagnosis of T2D. This was achieved by:

- Stratifying patients with a diagnosis of T2D according to CVD risk and status, and current glycaemic control
- Pharmacist-led reviews for patients identified as at risk of poor outcomes
- Provision of reports to support the practice in driving and maintaining quality improvement for patients with T2D

## METHODOLOGY

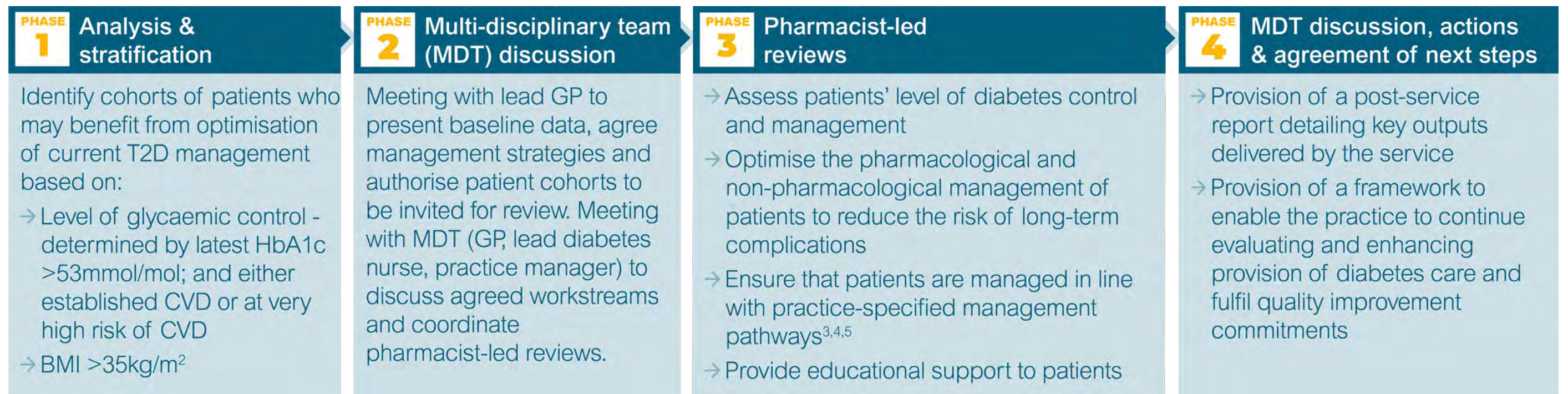


FIG. 1 REVIEW PROCESS

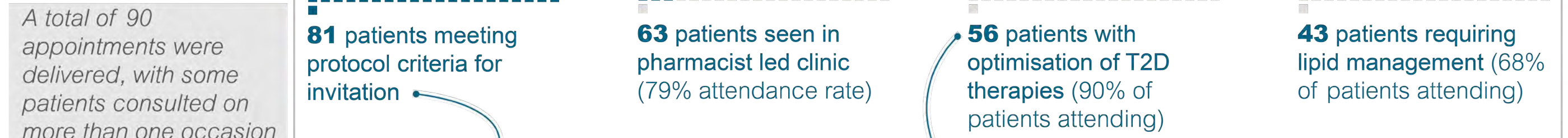


FIG. 2 COHORT CATEGORISATION ACCORDING TO CLINICAL RECORD AND PRESENTATION AT CLINIC

	Established CVD, HbA1c >53 mmol/mol, 1/2/3 non insulin antidiabetic drugs (NIAD) <b>(28 Patients) 35%</b>
	Very high risk of CVD, HbA1c > 53 mmol/mol, 2/3 NIAD <b>(50 Patients) 61%</b>
	BMI > 35 (independent of CVD risk, HbA1c and No. of meds) <b>(3 Patients) 4%</b>

FIG. 3 T2D THERAPY INTERVENTIONS FOR PATIENTS ATTENDING CLINIC

<b>1</b> dose decrease	<b>21</b> dose increase	<b>50</b> initiations
<b>1</b> change within class	<b>26</b> discontinue therapy	<b>2</b> change of formulation

FIG. 4 INITIATIONS BY ANTIDIABETIC DRUG CLASS

	<b>26</b> Glucagon-like peptide-1 receptor agonist (GLP-1 RA)
	<b>20</b> Sodium-glucose cotransporter 2 inhibitor (SGLT2i)
	<b>4</b> Other

## RESULTS

Based on the inclusion criteria, using data within the electronic health record, 81 patients were invited to pharmacist-led clinic (figure 2). 63 patients (79%), attended a pharmacist-led clinic over a total of 90 appointments.

Following the pharmacist-led clinics, recommendations for changes to management were agreed with the GP and a total of 101 pharmacological interventions (figure 3) were implemented to support patient care.

46 (92%) of the initiations (Figure 4) were for glucagon-like peptide 1 receptor agonist (GLP- 1RA) and sodium-glucose cotransporter 2 inhibitor (SGLT2i) therapy classes, which have demonstrated a reduction in major adverse cardiovascular events (MACE) in cardiovascular outcome trials (CVOTs) for patients with T2D and established or very high risk CVD<sup>3,5</sup>.

Patients were also recommended for review

of their lipid and blood pressure management to reduce their risk of cardiovascular complications<sup>3</sup>. Of the 63 patients reviewed, the pharmacist identified 43 patients (68%) requiring lipid management (figure 1) and 8 patients (13%) requiring blood pressure management, who were highlighted to the practice for follow up.

## DISCUSSION & LEARNING POINTS

The process demonstrated that through proactive patient identification and assessment of patients at risk of poor outcomes, improvements can be achieved in the management of patients living with diabetes and CVD, leading in turn to potential reductions in complications and MACE.

Many patients with T2D are not managed optimally in line with their CVD risk. This could be in part due to regular clinical guideline updates and recent clinical trial outcomes, challenges in proactive identification of patients at risk of poor outcomes, and routine care disruption due to COVID-19.

Whilst this review did not allow for evaluation of clinical outcomes, we anticipate that by recommending appropriate non-pharmacological interventions and pharmacological treatments that consider comorbidities and CVD risk, pharmacist-led clinical reviews such as this would lead to a reduction in cardiovascular complications of T2D.

Working collaboratively with the practice MDT helped to embed the learnings from this clinical review. In addition, provision of a framework to enable the practice to continue evaluating and enhancing provision of diabetes care supports sustained improvement in patient care.

## REFERENCES

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